General

Guideline Title

UK national guideline for the management of chancroid 2014.

Bibliographic Source(s)

Clinical Effectiveness Group. UK national guideline for the management of chancroid. London (UK): British Association for Sexual Health and HIV (BASHH); 2014 Mar. 22 p. [63 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guideline for the management of chancroid. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [51 references]

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 12, 2016 – Fluoroquinolone Antibacterial Drugs : The U.S. Food and Drug Administration (FDA) is advising that the serious side effects associated with fluoroquinolone antibacterial drugs generally outweigh the benefits for patients with sinusitis, bronchitis, and uncomplicated urinary tract infections who have other treatment options. For patients with these conditions, fluoroquinolones should be reserved for those who do not have alternative treatment options.

Recommendations

Major Recommendations

Levels of evidence (I-IV) and grades of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

Diagnosis

A number of papers have summarised the current approach to diagnosis. The main methods revolve around the identification of *Haemophilus*

ducreyi (*H ducreyi*) by:

- Detection of nucleic acid (DNA) by amplification techniques such as polymerase chain reaction (PCR), using nested techniques. There are no commercial assays available, but a number of specialised or research laboratories have published their in-house methods.
- Culture of material obtained from the ulcer base, or the undermined edges of the ulcer, after removing superficial pus with a cotton-tipped swab, or from pus aspirated from the bubo. The material can be plated directly onto culture medium incubated at 33°C in high humidity with 5% carbon dioxide for a minimum of 48 to 72 hours.

Culture media include:

- *Gonococci* (GC) agar supplemented with 1% to 2% bovine haemoglobin, 5% fetal calf-serum
- Mueller-Hinton agar enriched with 5% chocolatised horse blood
  Both of these also require supplements of 1% IsoVitaleX, and 3mg/L vancomycin to prevent overgrowth of Gram positive organisms.

- Modification of these techniques by substitution of 0.2% activated charcoal instead of fetal calf serum has proven equally effective and is much cheaper.

The use of more than one medium increases sensitivity, which is still low (<80%). Since *H ducreyi* is a fastidious organism, specimens should be plated out directly at the clinic or sent rapidly (within 4 hours) to the laboratory; calcium alginate or plastic swabs should be used for sample collection; special transport medium may be helpful if culture media are not readily available. Confirmatory testing for oxidase, alkaline phosphatase, nitrate reduction and porphyrins can be used.

Microscopy of a Gram stained smear (or other stains) of material from the ulcer base or of pus aspirate from the bubo may show characteristic gram-negative coccobacilli, with occasional characteristic chaining. The test has low sensitivity and is not recommended as a diagnostic test.

Expert opinion has estimated that, in endemic areas, a positive *H ducreyi* culture is achievable in 60% to 80% of patients considered to have chancroid on clinical grounds. Microscopy is only 50% sensitive compared to culture, and prone to multiple errors, given the polymicrobial flora of many ulcers. PCR is the most sensitive technique, and has been demonstrated to be 95% sensitive compared to culture; conversely culture may be only 75% sensitive relative to PCR. However, PCR may be negative in a number of culture-proven chancroid cases owing to the presence of Taq polymerase inhibitors in the DNA preparations extracted from genital ulcer specimens. Multiple PCR assays have also been developed for the simultaneous amplification of DNA targets from *H ducreyi*, *Treponema pallidum* and herpes simplex virus (HSV) types 1 and 2.

Other Diagnostic Methods

Other diagnostic tests have included various antigen-detection techniques involving immunofluorescence or radio-isotopic probes but these are not used currently in the United Kingdom (UK).

Serology

The detection of antibody to *H ducreyi* as a marker of chancroid has been effective in a number of epidemiological studies with enzyme-linked immunoassays (EIAs) using either lysed whole cell, lipo-oligosaccharide (LOS) or outer membrane proteins (OMPs) as antigen sources. However, for the individual patient, the method lacks sensitivity, specificity (cross-reaction with other Haemophilus species) and cannot distinguish between remote and recent infection.

To circumvent the many problems of confirming a positive diagnosis of chancroid, the Centers for Disease Control and Prevention (CDC) in the United States of America (USA) have proposed that a "probable diagnosis", for both clinical and surveillance purposes be made if the patient has one or more painful genital ulcers, and (a) no evidence of *T pallidum* infection by dark field examination of ulcer exudate or by a serologic test for syphilis performed at least 7 days after onset of ulcers, and (b) the clinical presentation, appearance of the genital ulcers and regional lymphadenopathy, if present, is typical for chancroid and a test for HSV performed on the ulcer exudate is negative.

Clinical Diagnosis

A number of studies have found that the clinical diagnosis of genital ulcers is often unreliable with an accuracy ranging from 33% to 80%, even in areas of high prevalence and good clinical expertise. However, the true accuracy may be higher. Some of these studies suffered because of the low sensitivity of culture methods used. Previously this would not have mattered too much as syndromic management would cover the significant prevalence of mixed infections - co-infections of *H ducreyi* with *T pallidum* or HSV were frequent, occurring in over 10% of patients in many African studies. However, now that the prevalence of chancroid has decreased it is likely that the use of syndromic management too will decrease and clinical diagnosis may assume increased importance.

Management

General Advice

1. Patients should be advised to avoid sexual intercourse until they and their partner(s) have completed treatment and follow-up.
2. Patients should be given a detailed explanation of their condition with particular emphasis on the long-term implications both for their health and that of their partner(s). This should be reinforced by giving them clear and accurate written information.

Further Investigations

Screening for other possible causes of genital ulcerative disease should be undertaken, particularly for syphilis, genital herpes, lymphogranuloma venereum (LGV) or donovanosis. Full sexually transmitted disease (STD) screening should be offered. Biopsy of lymph nodes may be required to exclude neoplasia, if lymphadenopathy does not resolve following treatment.

Treatment

Successful treatment of chancroid should cure infection, resolve clinical symptoms, and prevent transmission to sexual partners.

It should be noted that no comparative treatments have been published since 1999 in which chancroid has been confirmed by culture or PCR. The main treatment options are presented in Table 1 in the original guideline document (summarised below) and most are similar to the 2010 CDC guidelines from the USA. Evidence of their clinical efficacy has been obtained in randomised controlled trials for some (level of evidence Ib). However, grading of recommendation also takes account of ease of administration, side effects and compliance.

Recommended Regimens

- Azithromycin 1 g orally in a single dose (Ib, A)
  or
- Ceftriaxone 250 mg intramuscularly (IM) in a single dose (Ib, B)
  or
- Ciprofloxacin 500 mg orally in a single dose (Ib, B)
  or
- Ciprofloxacin 500 mg orally two times a day for 3 days (Ib, B/A)
  or
- Erythromycin base 500 mg orally four times a day for 7 days (Ib, B/A). This is also recommended for human immunodeficiency virus (HIV) positive patients rather than the single dose regimens.

Azithromycin and ceftriaxone offer the advantage of single-dose therapy. They have excellent in vitro activity against *H ducreyi* with no reported resistance. However, a study comparing single dose treatment of chancroid using thiamphenicol versus azithromycin found that all 4 HIV positive cases treated with azithromycin failed therapy. Moreover, in this study chancroid was diagnosed after exclusion of syphilis by clinical characterisation of genital necrotic and painful sores and positive Gram stains and not by culture or PCR.

Erythromycin given at high doses for 7 days is the World Health Organization (WHO)-recommended first line treatment for chancroid. Although efficacious (with cure rates of 93% noted in Kenya and India) poor compliance and gastrointestinal intolerance make alternative therapy desirable (Ib, B). Lower dosage and simpler regimens of erythromycin have been evaluated in two separate trials in Kenya. Cure rates of 91% were achieved in a randomised double blind trial of erythromycin 500 mg three times daily for 7 days (versus a single dose of ciprofloxacin) (Ib, B). The efficacy of an even shorter regimen (250 mg three times daily for 5 days) was reportedly high in a small trial conducted by the same team, but this was not a randomised comparative trial (III, C).

Worldwide, several isolates with intermediate resistance to either ciprofloxacin or erythromycin have been reported, thus single dose ciprofloxacin and the shorter (5-day) regimen of erythromycin may not be effective, as has been reported by teams in Rwanda and Malawi. However, a double-blind randomised-controlled trial conducted in Nairobi showed comparable cure rates for single dose ciprofloxacin (92%) and the standard 7-day course of erythromycin (91%).

Widespread resistance to trimethoprim-sulfamethoxazole (TMP-SMX) renders this cheap and once effective alternative virtually useless.

Alternative Regimens

- Oral single dose fluoroquinolones such as fleroxacin 400 mg, or norfloxacin 800 mg (Ib, B)

- Single dose aminoglycoside such as spectinomycin 2 g IM (IIa, B).

Single dose thiamphenicol 5 grams dissolved in 50 ml of water in a single oral dose was effective in presumed cases of chancroid in Brazil.

Allergy

Patients allergic to quinolones or cephalosporins should be treated with the erythromycin regimen.

Special Considerations

Treatment for Pregnant or Lactating Mothers and Treatment for Children

The safety of azithromycin for pregnant and lactating women has not been established. Ciprofloxacin is contraindicated for pregnant and lactating women, children, and adolescents less than 18 years of age in which case erythromycin or ceftriaxone regimens should be used. No adverse effects of chancroid on pregnancy outcome or on the fetus have been reported.

HIV Infection

- Probable increased incidence of delayed healing and treatment failures though evidence is conflicting.
- Treatment of choice is erythromycin 500 mg 4 times a day (qds) for 7 days.

Patients co-infected with HIV should be closely monitored. There have been concerns that healing may be slower among HIV-infected people and treatment failures have been frequently recorded in Kenya using azithromycin, ceftriaxone, or single dose fleroxacin and in Malawi using low dose erythromycin or ciprofloxacin. A higher treatment failure rate among HIV-infected patients has, however, not been observed by the same Kenyan team in a study using low dose erythromycin or single dose ciprofloxacin. In Rwanda, researchers found that HIV and the degree of immunosuppression as measured by CD4 counts had no effect on bacteriologic and clinical outcomes, and that treatment failures were entirely attributable to resistance of *H ducreyi* to TMP-SMX. Dosage and duration of the fleroxacin regimen also needed to be increased to treat HIV-infected patients in Nairobi. CDC recommends that "since data on therapeutic efficacy with the recommended ceftriaxone and azithromycin regimens among patients infected with HIV are limited, those regimens should be used among persons known to be infected with HIV only if follow-up can be assured." Others have concluded that azithromycin should be avoided in co-infected patients. The case for using erythromycin was borne out by the acceptable response to syndromic management that was not related to HIV-1 infection when this drug was used in a study in Durban.

A Cochrane review done to investigate whether genital ulcer disease treatment reduced sexual acquisition of HIV identified 3 studies, 2 of which involved treatment of chancroid in Nairobi involving HIV negative men. The former trial compared fleroxacin to TMP-SMX and the latter investigated 2 different doses of fleroxacin. The cure rates for chancroid were both very high. Not surprisingly HIV acquisition was not reduced given the short follow up - presumably seroconverters would have acquired chancroid and HIV from an untreated HIV positive contact at the same time prior to any treatment. However, the conclusion of the Cochrane review was that there was insufficient evidence that treatment of genital ulcer disease reduces sexual acquisition of HIV infection. The results of this review once again demonstrate both the difficulties in designing trials that might be capable of investigating the link between sexually transmitted infections (STIs) and HIV transmission amongst casual sex acts - one of the main determinants in the spread of HIV, and the need to undertake reviews in areas where there is significant biological plausibility in the question asked.

Management of Fluctuant Buboes

The classic strategy has been to needle-aspirate fluctuant buboes from adjacent healthy skin. The procedure is simpler and safer than incision, which is prone to complications (sinus formations). A randomised study conducted during an outbreak of chancroid in the USA has shown that careful incision and drainage was also an effective and safe method for treating fluctuant buboes and avoided frequent needle re-aspirations. This procedure should always be performed under effective antibiotic cover.

Follow-Up

Patients should be re-examined 3 to 7 days after initiation of therapy. If treatment is successful, ulcers improve symptomatically within 3 days and substantial re-epithelization occurs within 7 days after onset of therapy. The time required for complete healing is related to the size of the ulcer (and perhaps HIV-related immunosuppression; large ulcers may require more than 2 weeks). Clinical resolution of fluctuant lymphadenopathy is slower than that of ulcers and may require frequent needle aspiration (or drainage).

A test of cure is not recommended.

Treatment failures should warrant: (i) investigation of possible coinfections with *T pallidum* or HSV; or (ii) determination of possible resistance by

isolation of *H ducreyi* and susceptibility testing by the agar dilution technique to determine minimal inhibitory concentrations but this requires a specialised laboratory.

Sexual Partner(s) Management

Persons who have had sexual contact with a patient who has chancroid within the 10 days before onset of the patient's symptoms should be examined, and treated even in the absence of symptoms, as asymptomatic carriage of *H ducreyi* has been proven to occur, but screening is not recommended.

Definitions:

Levels of Evidence

Level	Type of Evidence
Ia	Evidence obtained from meta-analysis of randomised controlled trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomisation
IIb	Evidence obtained from at least one type of well-designed quasi-experimental study
III	Evidence obtained from well-designed, non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grading of Recommendations

Grade	Recommendation
A (Evidence levels Ia, Ib)	Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation
B (Evidence levels IIa, IIb, III)	Requires availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation
C (Evidence level IV)	Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Chancroid

Guideline Category

Diagnosis

Evaluation

Management

Treatment

Clinical Specialty

Infectious Diseases

Obstetrics and Gynecology

Urology

Intended Users

Advanced Practice Nurses

Nurses

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

To offer recommendations on the diagnosis, treatment and health promotion principles for the effective management of chancroid

Target Population

People aged 16 years and older presenting to services offering Level 3 care in sexually transmitted infection (STI) management within the United Kingdom (UK)

Interventions and Practices Considered

Diagnosis/Evaluation

1. Identification of *Haemophilus ducreyi* (*H ducreyi*)
    - Detection of nucleic acid (DNA) by amplification techniques such as polymerase chain reaction (PCR)
    - Culture of material from the ulcer base or of pus aspirate from the bubo
    - Microscopy of Gram stained smear of material from the ulcer base or of pus aspirate from the bubo (not recommended)
2. Criteria for making a "probable diagnosis"
3. Further investigations
    - Screening for other possible causes of genital ulcer disease
    - Full sexually transmitted disease (STD) screening
    - Biopsy of lymph nodes to exclude neoplasia

Management/Treatment

1. Providing patients with information about their condition and advice to avoid sexual intercourse until treatment completion and follow-up
2. Pharmacological interventions
    - Azithromycin
    - Ceftriaxone
    - Ciprofloxacin
    - Erythromycin
    - Fleroxacin or norfloxacin
    - Spectinomycin

    - Thiamphenicol
3. Management of fluctuant buboes
    - Needle aspiration from adjacent healthy skin
    - Incision and drainage
4. Special treatment considerations for pregnant women, lactating mothers, children and individuals with human immunodeficiency virus (HIV) infection
5. Sexual partner management
6. Follow-up
    - Examination 3 to 7 days after initiation of therapy
    - Needle aspiration or drainage (fluctuant lymphadenopathy)
    - Treatment failures
        - Investigation of possible co-infections with *Treponema pallidum* (*T pallidum*) or herpes simplex virus (HSV)
        - Determination of possible resistance by isolation of *H ducreyi* and susceptibility testing by the agar dilution technique

Major Outcomes Considered

- Accuracy, sensitivity, and specificity of diagnostic tests
- Clinical efficacy of treatment (cure rate)
- Treatment failure

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The review has been updated by searching PubMed from 1999 to 2013 using the search terms/medical subject headings (MeSH) headings: "Chancroid"; "Chancroid and diagnosis"; "Chancroid and treatment"; "*Haemophilus ducreyi* diagnosis"; "*Haemophilus ducreyi* treatment"; and "Chancroid and randomized trial". The Cochrane Library was searched from 1957 to 2013 using the MeSH headings "chancroid" and "*Haemophilus ducreyi*" as were the U.S. Centers for Disease Control and Prevention (CDC) Sexually Transmitted Disease (STD) guidelines of 2010, World Health Organization (WHO) STD guidelines and the 2011 European Guideline for the Management of Chancroid. In addition, abstracts and proceedings from the most recent International Conferences on Acquired Immune Deficiency Syndrome (AIDS), Meetings of the International Society for STD Research (ISSTDR) and British Association for Sexual Health and HIV (BASHH) Spring Meeting were reviewed.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level	Type of Evidence

Level	Type of Evidence
Ia	Evidence obtained from meta-analysis of randomised controlled trials
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IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Guideline development is undertaken by a multi-disciplinary writing committee with membership determined in a transparent manner. The chair is chosen by the Clinical Effectiveness Group (CEG). The CEG lead then discusses with the chair what suggestions they might have for members from other disciplines. The additional members of the group are then invited by the CEG. Writing committee membership includes relevant professional groups (for example genitourinary medicine physicians, nurses, health advisors, pharmacists, microbiologists and other professionals from allied specialties as appropriate) and when relevant this will involve working with the appropriate British Association for Sexual Health and HIV (BASHH) Special Interest Group (SIG) and the BASHH audit group.

Patients' views and preferences are sought and considered and the process documented. This may include patient representative involvement in the writing committee, information obtained from patient interview or surveys during the writing and/or piloting process, reviewing published work on patient experiences or involving patient associations. The chair of the writing group identifies an appropriate member such as the Health Advisor to get patient feedback on the guideline. BASHH is currently developing a public panel to assist with its work and in the future this group could be approached to assist in guideline development.

Recommendations are formulated with consideration of their health benefits, side effects and risks, with evidence presented in the guideline that these issues have been addressed. Each recommendation is linked to the supporting evidence with a list of relevant references.

Consideration is given to pragmatic and organisational issues relevant to the guideline. This is sought during and may emerge from the piloting of the guideline.

The authors consider the financial cost implications of recommendations made. Where disagreement arises within the writing committee with regard to recommendations the chair attempts to resolve these (for example by a voting system or formal consensus method). The process is documented and reported to the CEG editor. When this is not possible the CEG will review the evidence themselves and invite the chair and possibly other members of the writing committee to a meeting to agree a resolution and final recommendations.

Rating Scheme for the Strength of the Recommendations

Grading of Recommendations

Grade	Recommendation

Grade	Recommendation
A (Evidence levels Ia, Ib)	Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation
B (Evidence levels IIa, IIb, III)	Requires availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation
C (Evidence level IV)	Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Clinical Validation-Pilot Testing

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The initial draft of the guideline, including the patient information leaflet (PIL) was piloted for validation by the Clinical Effectiveness Group (CEG).

The final guideline was then reviewed by the CEG using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument before posting it on the British Association for Sexual Health and HIV (BASHH) website for external peer review for a two month period. Comments received were collated by the CEG editor and sent to the guideline chair for review and action. The final guideline was approved by the CEG and a review date agreed before publication on the BASHH website.

The rare nature of this disease precluded the review of this guideline by a patient suffering from chancroid. However, the guideline was reviewed by the BASHH *Patient and Public Engagement* panel which includes members of the public, representatives of sexual health voluntary sector organisations, young people's groups and sexual health professionals.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is graded and identified for select recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of individuals with chancroid

Potential Harms

Although erythromycin is efficacious (with cure rates of 93% noted in Kenya and India), poor compliance and gastrointestinal intolerance make alternative therapy desirable.

Contraindications

Contraindications

Ciprofloxacin is contraindicated for pregnant and lactating women, children, and adolescents less than 18 years of age.

Qualifying Statements

Qualifying Statements

Suggestions for diagnostic approaches made in this guideline should be tailored to local resources. This guideline recommends the use of nucleic acid amplification test (NAAT) and culture tests to diagnose *Haemophilus ducreyi* infection. However, these tests may not be routinely available except in specialised laboratories.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Clinical Effectiveness Group. UK national guideline for the management of chancroid. London (UK): British Association for Sexual Health and

HIV (BASHH); 2014 Mar. 22 p. [63 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1999 Aug (revised 2014 Mar)

Guideline Developer(s)

British Association for Sexual Health and HIV - Medical Specialty Society

Source(s) of Funding

This guideline was commissioned, edited and endorsed by the British Association for Sexual Health and HIV (BASHH) Clinical Effectiveness Group (CEG) without external funding being sought or obtained.

Guideline Committee

Clinical Effectiveness Group (CEG)

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

None declared

All members of the guideline writing committee completed the British Association for Sexual Health and HIV (BASHH) conflict of interest declaration at the time the guideline's final draft was submitted to the Clinical Effectiveness Group (CEG).

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guideline for the management of chancroid. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [51 references]

Guideline Availability

Electronic copies: Available from the British Association for Sexual Health and HIV Web site .

Availability of Companion Documents

The following is available:

- Clinical Effectiveness Group. British Association for Sexual Health and HIV: framework for guideline development and assessment. London (UK): British Association for Sexual Health and HIV (BASHH); 2010. 18 p. Electronic copies: Available from the British Association for Sexual Health and HIV Web site .

In addition, auditable outcomes measures are provided in the original guideline document .

Patient Resources

None available

NGC Status

This summary was completed by ECRI on December 8, 2000. The information was verified by the guideline developer on January 12, 2001. This summary was updated on June 24, 2002. This summary was updated by ECRI Institute on October 3, 2007 following the U.S. Food and Drug Administration (FDA) advisory on Rocephin (ceftriaxone sodium). This summary was updated by ECRI Institute on June 24, 2014. The updated information was verified by the guideline developer on July 24, 2014. This summary was updated by ECRI Institute on May 18, 2016 following the U.S. Food and Drug Administration advisory on Fluoroquinolone Antibacterial Drugs.

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